



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Nacogdoches Medical Center Hospital

Respondent Name

TASB Risk Management Fund

MFDR Tracking Number

M4-26-0479-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 20, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 10, 2024	250	\$8,045.00	\$0.00
	272	\$4,437.00	\$0.00
	278	\$64,444.00	\$0.00
	320	\$1,279.00	\$0.00
	360	\$101,192.00	\$0.00
	370	\$8,506.00	\$0.00
	636	\$9,097.00	\$0.00
	710	\$4,719.00	\$0.00
	WC Adjustments	-\$216,905.00	
Total		\$21,363.00	\$0.00

Requester's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed TASB, but the bill was denied not paid/reimbursed appropriately. However, despite the Hospital's efforts and Request for Reconsiderations sent, TASB has not rendered proper payment."

Amount in Dispute: \$21,363.00

Respondent's Position

"Current bill ... we are standing on the previous denial per the State of Texas Timely Filing and also the MFDR must be filed in the form and manner prescribed by the division."

Response Submitted by: TASB Risk Management Fund

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier denied payment for the disputed services with the following claim adjustment codes:

- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 29, X29 - The time limit for filing has expired.
- 350 - Bill has been identified as a request for reconsideration or appeal.
- 351 - No additional reimbursement allowed after review of appeal/reconsideration.
- ART - TX Rule 133.250(B) a health care provider shall submit a request for reconsideration no later than 10 months from the date of service.
- W3 - In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 16 – Claim/service lacks information or has submission/billing error(s).

- 241 – Not documented.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 618 – The value of this procedure packaged into the payment of other services performed on the date of service.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- 375 – Please see special *note* below.
- Note: please resubmit complete billing, itemized along with operative report and supporting documentation for services rendered and provide authorization as currently we continue to stand on denial per UR denial.

Issues

1. Is the Requester eligible for DWC medical fee dispute resolution for the services in question?

Findings

1. The requester is seeking reimbursement for emergency hospital visit services provided on September 10, 2024. According to 28 Texas Administrative Code (TAC) §133.307(c)(1), a request for Medical Fee Dispute Resolution (MFDR) must be submitted no later than one year after the date of the disputed service, except in certain limited circumstances outlined in subsection (B) of the same provision.

Specifically, 28 TAC §133.307(c)(1)(B) allows for a later filing if one of the following conditions applies:

- (i) A related dispute concerning compensability, extent of injury, or liability under Labor Code Chapter 410 has been filed. In such cases, the medical fee dispute must be submitted within 60 days after the requester receives the final decision on compensability, extent of injury, or liability, including all appeals.
- (ii) A dispute regarding medical necessity has been filed. Here, the medical fee dispute must be filed within 60 days after the requester receives the final decision on medical necessity, including all appeals, for the specific health care services in question that were previously denied by the insurance carrier on the basis of medical necessity.
- (iii) The dispute arises from a refund notice issued following a division audit or review. In this situation, the medical fee dispute must be filed within 60 days after the requester receives the refund notice.

In this case, emergency hospital services were provided on September 10, 2024. The Division received the MFDR request on October 20, 2025, which is more than one year after the date of service. Upon review of the documentation provided, there is no indication that the dispute falls within any of the exceptions described in 28 TAC §133.307(c)(1)(B).

Therefore, the Division concludes that the requester failed to file the MFDR request within the required timeframe and has consequently waived the right to pursue Medical Fee Dispute Resolution for this claim.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The Division finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the Division has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	November 4, 2025
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. The Division must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to the Division using the contact information on the form or the field office handling the claim. If you have questions about the DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.